Print, Complete and Mail or Fax To:	
New York State Department of Health P.O. Box 2051 Empire State Plaza Station Albany, NY 12220-0051 (518) 486-2938 (518) 474-7381 (FAX)	Approved:_____ Disapproved:_____ Notified:_____

Request for Exemption from Mandatory Infection Control Training Based on Nature of Professional Practice

(Applicants using this form must be physicians, registered physician assistants, or specialist assistants)

Chapter 786 of the Laws of 1992 established a requirement that certain health care professionals receive training in infection control and barrier precautions by July 1, 1994 and every four years thereafter, unless otherwise exempted. The statute authorizes the Department of Health to oversee the law as it applies to physicians, registered physician assistants (PAs), and specialist assistants (SAs) including the granting of exemptions.

Physicians, PAs and SAs who believe they meet the criteria listed below and wish to be considered for an exemption must print, complete and sign this form, and return it to the Department of Health. A notification of approval or disapproval of this request will be mailed within thirty (30) working days of receipt of this form. The Department of Health reserves the right to request additional information as necessary.

Please type or print:

Last Name:_____ First:_____ MI:_____
Street Address:_____
City, State and Zip:_____
Profession:_____ License #:_____
Daytime/Work Telephone Number: (___)_____
E-mail: _____

Exemption Criteria

Please indicate the criteria upon which you base your request for exemption:

- ☐ Retired and no longer in active practice
- ☐ Interruption of active practice until: _____
- ☐ Not practicing in New York State
- ☐ Do not provide direct patient care or oversee individuals or programs where others are responsible for providing patient care or reprocessing patient care equipment.
- ☐ Other practice category - please describe on back of form

Attestation

In submitting this request for an exemption, I affirm that the information I am providing is true and correct. I understand that if my status changes, I will provide written notification to the Department of Health within thirty (30) days of the occurrence of such change and attend an approved training program within ninety (90) days of the change.

Signature:_____Date:_____